BAYSTATE MEDICAL CENTER, INC.
MEDICAL STAFF RULES AND REGULATIONS

I. ADMISSION AND DISCHARGE PROCEDURES

A. Baystate Medical Center, Inc. (the “Medical Center”) will accept all patients for care and treatment regardless of race, sex, age, color or creed or ability to pay.

B. A patient may be admitted to the Medical Center only by a member of the Medical Staff (“Member”) with admitting privileges. Patients applying for admission without a Member will be assigned a Member on the service to which the illness of the patient indicates assignment or, if applicable, the patient may request a specific Member from the Medical Staff Roster. The Member to whom the patient is assigned, who may be the admitting or the attending Member, is responsible for the patient (“the responsible Member”). In the case of patients admitted by a Member but assigned to an associate health professional or allied health professional (“Associate Health Professional”), the Associate Health Professional is responsible for the patient’s general medical condition and for assessing the medical risks of any proposed surgical procedures. Residents and other participants in professional graduate education programs may not admit patients to the Medical Center. A Member who assigns any patient care activities related to admission or discharge to a resident or other participant in a professional education program must ensure that such person is supervised in accordance with Medical Center policies.

C. All patients admitted for inpatient care shall have a history taken and a comprehensive physical examination performed by a Member who has such privileges. Associate Health Professionals who are assigned patients are responsible for the part of their patients’ history and physical examination that relates to the Associate Health Professional’s area of specialty.

D. All patients admitted will be screened against third party payor pre-admission guidelines to determine whether the admission will be covered. It is the admitting Member’s responsibility to comply with pre-admission screening requirements and to communicate the approvals to the Medical Center’s pre-admission staff as requested. In the event an admission is not covered by third party payor reimbursement, the Member and patient will be notified by the external reviewer. Coverage by third party payors is not a pre-requisite for admission to the Medical Center, however.
E. Access Services/Patient Registration/Admissions will admit patients on the basis of the following order of priority:

1. **Emergency Admissions**: Patients with an immediate threat to life or well being. Patient requires admission on that day.

2. **Urgent Admissions**: Patient whose medical condition requires admission within five days.

3. **Elective Admission**: Patient whose medical condition does not require admission within five days.

F. The responsible Member is responsible for communicating to the appropriate Medical Center personnel such information as he or she may have available regarding an admitted patient’s potential as a source of danger to himself or herself or to others.

G. The responsible Member is required to document the need for hospitalization by a provisional diagnosis and treatment plan as well as the need for continued hospitalization in the form of timely (or daily if it is the Medical Center procedure) progress notes which describe the patient’s current status and plans for continued treatment.

H. Patients will be discharged only on the order of the responsible Member, except in the case of a disaster when the Medical Center President or his designee, the Chairs of the Departments, or the President of the Medical Staff are empowered to make such discharges as are necessary to ensure the care and treatment of disaster casualties.

I. Should a patient leave the Medical Center against the advice of the responsible Member or without proper discharge, a notation of the incident must be made in the patient’s medical record.

J. The responsible Member should document his or her intention to discharge a patient, and discuss with the patient and family, as soon as possible after the decision is made, preferably twenty-four (24) hours prior to the anticipated date of discharge and consistent with Medical Center policy and relevant law. The responsible Member is encouraged to write and/or enter orders for discharge prior to 9:00 a.m. on the date of discharge in order to comply with Medical Center policy.
K. Members of the Medical Staff are responsible for the medical care and treatment of their patients in the Medical Center, for the completeness and accuracy of the medical record describing the need for an acute hospital level of care, for necessary special instructions and for transmitting reports of the condition of the patient to the referring physician and to the relatives of the patient.

L. Whenever the responsibilities of the responsible Member are transferred to another Member, a note covering the transfer of responsibility must be entered in the medical record. The transfer becomes effective only after the accepting Member signifies assent. Any Member who admits a patient to the Medical Center is responsible for the care of that patient and should that Member wish to discontinue his or her services to that patient, he or she will be permitted to do so only if another Member has assumed this responsibility. Similarly, a patient may not discharge a Member until the patient has arranged for another Member to assume the responsibility of the care of that patient.

M. Whenever a patient becomes seriously ill, or whenever a patient expires, the responsible Member shall notify the family as soon as possible.

N. The responsible Member and other such practitioners as are required by law are responsible for reporting specific communicable diseases, abused and neglected children and elders, assaults, dog bites, gun shot wounds, and such other diseases required by law to the proper authority in accordance with Medical Center policy.

O. The admission, care and discharge from Critical Care Units and other special units of the Medical Center established for the care of the seriously ill patient will be governed by policies of those units as published from time to time.

P. It is the responsibility of every Member of the Medical Staff to request autopsies in accordance with Medical Staff approved criteria and particularly in those cases where the exact cause of the clinical event which led to death is uncertain or where insight into the cause, nature or course of a disease process may be obtained. Proper consent for an autopsy shall be obtained in accordance with Medical Center policy and relevant law. The Medical Staff, and specifically, the responsible Member, will be notified of the autopsy in accordance with Medical Center policy and relevant law. All autopsies shall be performed by a Medical Center pathologist, or by his or her qualified designee. The provisional anatomic diagnosis must be recorded on the medical record within three (3) days. The complete protocol shall be made a part of the medical record within thirty (30) days, unless special studies are required which may delay completion of the Final Anatomic Diagnosis. These rules do not apply to cases which according to law must be referred to the Medical Examiner’s Office.
II. MEDICAL RECORDS

A. The responsible Member shall be responsible for the preparation of a complete, legible, pertinent and current medical record for each patient. Entries in the medical record may be made by Medical Staff Members, physicians in training, nurses, and other patient care providers within the scope of their privileges. Residents and other participants in professional graduate education programs must be supervised and may undertake patient care responsibilities and make entries in the medical record only in accordance with these rules and regulations and Medical Center policies. All such records not electronically generated must be dictated or written in permanent blue or black ink. All clinical entries must be promptly and accurately dated and authenticated by each individual, identified by name and discipline, who makes the entry and who is responsible for ordering, providing, or evaluating the services furnished. Use of a signature stamp is permitted; however, there may be no delegation of the use of such a stamp to another individual.

B. Required Medical Record Content:

1. **Inpatients.** The inpatient medical record must contain identification data, a complete history and physical examination ("H&P"); admitting diagnosis; documentation of allergies; evidence of informed consent when applicable (refer to specific Medical Center policy on Informed Consent); consultation, laboratory, radiology, and pathology reports; operative notes, when applicable; diagnostic and therapeutic orders, documentation of the patient’s psychosocial needs, as appropriate; documentation of all complications, Medical Center acquired infections, and unfavorable reactions to drugs and anesthesia, if applicable; progress notes; nurses’ notes; discharge summary; final diagnoses and discharge instructions. An autopsy report (when performed) is a part of the medical record.

   The name of the patient must be present on all medical record forms.

2. **Observation status patients.** For Observation status patients, the following recordkeeping components are required:

   a) a brief admission note on the Emergency Room ("E.R.") record, Progress Note Sheet, or short H&P form;
   b) admission note to include: symptoms, physical findings, assessment, need for Observation, and plan;
   c) Progress Notes p.r.n. and Doctor’s Order for disposition.

   If an Observation status patient becomes an inpatient, the H&P shall be in compliance with these Rules and Regulations concerning inpatient H&Ps.
3. **DayStay patients.** The DayStay medical record must contain identification data, an appropriate history and physical examination, documentation of allergies, evidence of informed consent, test results, when applicable, operative/procedure note, diagnostic and therapeutic orders, progress notes, and nurses’ notes. A discharge summary is not required; however, the disposition of the case will be included in the final progress note, and the final diagnoses and instructions to the patient must be recorded.

4. **Emergency Room patients.** The Emergency Department/Urgent Care/Trauma Service medical record must contain adequate patient identification, time and means of arrival at the Medical Center, significant clinical findings, results of procedures and tests, diagnostic and therapeutic orders, clinical observations, treatment, diagnosis, condition of patient on discharge, and final disposition including instructions for follow-up care. The medical record must note when the patient receiving emergency care leaves against medical advice. All entries in the Emergency Department medical record must be timely.

5. **Outpatients receiving blood transfusions.** Outpatients receiving blood transfusions require the following:

   a) initial H&P must be performed by the attending or primary care physician prior to administration of the blood transfusion;
   
   b) physician follow-up and/or continuation of transfusions to be noted on a physician prescription sheet noting no change in H&P;
   
   c) if treatment exceeds six (6) months, or the reason necessitating treatment has changed from the initial diagnosis(es), the attending/primary care physician will be required to document another H&P.

C. No changes or deletions are to be made on the medical record except in the case of error. Then a single line must be drawn through the error, the line marked as “error” and the line initialed by the practitioner making the change. The correct statement will then be made and signed by the practitioner. If necessary, a correction statement may be made by an addendum which must be dated and signed.

D. Copies of medical information concerning previous care are acceptable as supplemental information but not in lieu of history and physical examination requirements as in paragraph G2, below.

E. Symbols and abbreviations are discouraged due to possible ambiguity; however, they are acceptable, except that final diagnoses and complications should be recorded without the use of symbols or abbreviations.
F. The responsible Member must sign the discharge summary, history and physical examination, operative note, and labor & delivery summary when they have been recorded by a resident, physician assistant, or nurse practitioner. Prescriptions for Class II narcotics written by a non-physician with prescriptive authority must be countersigned by the supervising physician within 96 hours. All entries in the medical record recorded by a medical student must also be signed by the resident or responsible Member.

G. History and Physical Examination:

1. All H&Ps shall include the following: chief complaint, history of present illness, relevant past medical history, relevant social history, relevant family history, review of systems, comprehensive physical examination, provisional diagnosis/assessment, and treatment plan.

2. **Inpatient admission.** A complete H&P must be dictated or written and signed by the responsible practitioner. If the physical examination is performed by other than a physician, oral surgeon, certified nurse midwife, or podiatrist with the requisite clinical privileges, a physician Member of the Medical Staff must countersign it. Unless otherwise set forth herein, a complete H&P must be performed no more than seven (7) days prior to admission or within twenty-four (24) hours after admission. If an H&P has been performed within thirty (30) days before admission, a durable, legible copy of this report may be used in the patient’s medical records, provided that any changes that may have occurred are recorded in the medical record at the time of admission.

3. **Elective Surgery.** Similar to an inpatient admission, an H&P on a patient scheduled for elective surgery (whether inpatient or outpatient admission status) must be dictated or written no more than seven (7) days prior to surgery, and any changes that have occurred between the time of dictation and the time of surgery must be recorded in the medical record at the time of admission. If an H&P was performed within thirty (30) days before admission, a durable, legible copy of this report may be used in the patient’s medical records, provided that any changes that may have occurred are recorded in the medical record at the time of surgery; however, it must be updated with any new information within the seven (7) day mandated period. A brief note acknowledging any changes is acceptable. No elective surgery, or potentially dangerous elective diagnostic study, including cases where the administration of anesthesia or deep sedation is used, may be performed unless an H&P, including the pre-operative diagnosis performed by the practitioner responsible for the patient, and pre-anesthesia assessment, are in the medical record.
In any surgical procedure with unusual hazard to life, there must be a qualified assistant present and scrubbed. A licensed physician is required as an assistant during the performance of the operations. The specific operations are categorized according to the American College of Surgeons, and yearly the Operating Room circulates procedures that do and do not require an assistant.

4. **Emergency surgery:** For emergency surgery performed within two (2) hours of admission (either E.R. or inpatient), a written note documenting the patient’s condition that necessitates emergency surgery is required. In cases of surgical or medical emergency, a brief assessment of the clinical situation along with an adequate description of the significant clinical impairment should be noted. The complete history and physical examination must be completed, dictated and recorded within twenty-four (24) hours of admission. For urgent and elective admissions where surgery is scheduled for more than two hours after admission, a written or dictated H&P is required prior to surgery.

5. **Patients readmitted within 30 days.** For patients readmitted within thirty (30) days for the same or related diagnosis or problem, the patient’s record must contain the following components:

   a) a copy of the previous H&P may be placed on the chart; however, an interval note must also be added which must include reference to the previous note, an interval history noting any changes that have occurred, the patient’s current condition or circumstances, any changes in medications, etc., an update or any condition, and the reason for readmission;
   
   b) a limited physical examination noting any changes that have occurred;
   
   c) an assessment or impression; and,
   
   d) a plan.

6. **Obstetrical records.** Obstetrical records must include copies of the original of the office or clinic prenatal record. The prenatal record may be a legible copy of the attending physician’s office record transferred to the Medical Center before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

7. **Pre-anesthesia Assessments:** Each patient for whom anesthesia is contemplated must receive a pre-anesthesia assessment, which must be a part of the medical record. Pre-anesthesia assessment considers data from other assessments and collects information needed to select and plan anesthesia care, safely administer
anesthesia, and interpret findings of patient monitoring. Additional assessments made by the Member must be documented in the patient’s medical record. Pre-anesthesia assessments required are based on the type of anesthesia or sedation to be used:

a) Topical, local or regional block or no anesthesia
   1. assessment of mental status (documentation of informed consent from patient is sufficient evidence that patient is alert and oriented); and
   2. examination specific to the proposed procedure

b) IV Sedation - conscious sedation
   3. 1 & 2 above, plus
   4. auscultation of the heart and lungs

c) General, spinal or epidural anesthesia or deep sedation
   5. 1, 2 and 4 above, plus
   6. assessment and documentation of the patient’s general condition

Each patient must be reevaluated immediately before anesthesia induction.

H. Progress Notes:

1. Pertinent progress notes must be recorded at the time of observation in a manner which will relevantly document the necessity for continued hospitalization and permit continuity of patient care. Progress notes should give a pertinent chronological report of the patient’s course in the Medical Center and reflect any change in condition and the results of tests and treatment.

2. Progress notes may be recorded by Medical Staff Members, residents, and by other individuals within the scope of their privileges.

3. As a guideline, a legible progress note should be written every 24 to 48 hours.

4. An operative note (which includes findings at surgery, surgical technique, tissue removed or altered, complications, the condition of the patient at the termination of the operation, pre-operative and post-operative diagnosis, the name of the primary surgeon, and any assistants) must be recorded in the progress notes and authenticated by the surgeon immediately after surgery.

5. A progress note must be written on every patient who expires, stating the time and date of death and the events preceding death.
I. Anesthesia Record:

1. The anesthesia record shall include pre-anesthesia assessment, including review of patient’s condition, anesthesia procedure, recovery room follow-up, and shall include a post-anesthesia follow-up of patient’s condition, to be completed within forty-eight (48) hours after surgery for inpatients.

2. There shall be evidence of informed consent for the administration of anesthesia.

J. Operative Reports:

1. The operative report must include a detailed account of the findings at surgery, details of the surgical technique, tissue removed or altered, complications, the condition of the patient at the termination of the operation, pre-operative and post-operative diagnosis, the name of the primary surgeon and any assistants.

2. The use of a “standard” operative report for more than one patient is not acceptable.

3. Operative reports must be written or dictated immediately following surgery, promptly signed and made a part of the patient’s current medical record.

4. The medical record must contain evidence of informed consent for procedures and treatments.

K. Postoperative documentation:

Postoperative documentation records the patient’s vital signs and level of consciousness; medications (including intravenous fluids), blood, and blood components; any unusual events or postoperative complications; and management of such events. Postoperative documentation records the patient’s discharge from the post-anesthesia care area in accordance with Medical Center policy.

L. Consultations:

1. Members are encouraged to ask for consultations under the following conditions:

   a) When the diagnosis is obscure after ordinary diagnostic procedures have been completed;
   b) When there is doubt as to the choice of therapeutic measures to be utilized
   c) In unusually complicated situations where specific skills of other practitioners may be needed;
   d) When the patient exhibits severe psychiatric symptoms;
   e) In elective surgical cases with serious medical problems;
f) When requested by the patient or his responsible representatives;
g) When requested by the Chief of Service or the President of the Medical Staff.

2. When requesting inpatient consults, Members should state time frame in which consult is expected. The following time frames are recognized:

   a) STAT (Shall only be utilized in the event of emergency or immediate life-threatening situation where any delay could potentially jeopardize the patient’s welfare.)
   b) 24 Hours
   c) 72 Hours
   d) When available

3. It is the responsibility of the Member requesting the consultation to contact the consultant directly in the case of a STAT consultation request.

4. For consultations other than those requested on a STAT basis, it is the responsibility of the Member requesting the consultation or his or her designee to notify the consultant selected and to enter the specific reason for the consultation in the medical record. If the medical record is not yet transcribed, this information should be personally communicated to the consultant.

5. In the case that a consultant will not be available for consultation within the specified time requested, it is the responsibility of the Nursing Service to contact the Member requesting the consultation to either change the time within which the consultation can be obtained, or cancel the consultation order.

6. If the consult is dictated, it is the responsibility of the consultant to write an interval note.

7. In the case of a consult ordered in the E.R., it is the responsibility of the E.R. physician, in consultation with the admitting Member, to indicate the required time frame.

8. In the case of the consult with no indicated time frame, it is expected that the consult will be within twenty-four (24) hours.

9. The responsible Member is responsible for obtaining the permission of the patient or his or her delegate for the proposed consultations.

10. Any Member may be called for consultation in the area of his or her delineated privileges. Temporary consultation privileges may be granted to other practitioners in accordance with the Medical Staff Bylaws.
11. The Chief of the Pulmonary Division, or his or her designate, may see and review all patients and medical records of those cases receiving respiratory therapy.

12. A consultation will include examination of the patient and review of the medical record. A recorded opinion, signed by the consultant, must be included in the medical record.

13. Pre-operative consultations when obtained must be recorded prior to the operation except in an emergency.

14. In cases of patient care involving more than one physician:
   a) the responsible Member will designate which consultant is responsible for which patient problem, and whether or not the consultant can write orders relative to the problem;
   b) the responsible Member will be responsible for resolving any problems that may arise involving the consultant(s);
   c) if the responsible Member is not comfortable with managing a problem, then he or she shall transfer care to a Member who has agreed to accept the patient to his or her service;
   d) the responsible Member may designate a consultant to be a “co-manager” in which case the consultant can write orders appropriate to his or her area of expertise.

M. Admission, Diagnostic, and Therapeutic Orders:

1. Admission orders, including Diagnostic and Therapeutic orders, must be communicated (by telephone, in writing, or by entry into the Clinical Information System) by the admitting physician within two hours of admitting the patient or placing the patient in observation status. Emergency Department (“ED”) staff will accept admission orders, including therapeutic orders for the first 24 hours of care, by telephone only if the patient is still in the ED at the time the admitting physician calls with the orders. If a patient no longer is in the ED at the time the admitting physician calls with the orders, the admitting physician must telephone the admission orders to the hospital unit where the patient is located.

2. All orders for treatment or medication not entered into PCIS must be written clearly, legibly, and completely on the approved, patient-specific order sheet and must be signed by the responsible individual, including his or her name and professional designation.
3. A standing order is defined as an order which is not specific to an individual patient but pertains to a class of patients. Where standards of care have been established for a class of patients, individual orders for each test or treatment must still be written by the responsible Member.

4. Pre-printed orders require a conscious decision by the Member and are individualized for each patient (such as, but not limited to, clinical practice guidelines, post op order sets), and may be used provided that they conform to the guidelines for ordering and prescribing put forth and approved by the Medical Staff Executive Committee.

5. Diagnostic and therapeutic orders will be written by the responsible Member, by residents, and by other practitioners within the authority of their clinical privileges prior to being carried out by Medical Center personnel. Participants in professional education programs may write diagnostic and therapeutic orders for Medical Center patients only in accordance with these rules and regulations and Medical Center policy.

6. Telephone orders may be received and recorded by the appropriately authorized person (e.g., a registered nurse or licensed practical nurse) to whom dictated with the name of the Member giving the order. A registered physical therapist, registered respiratory therapist, registered dietitian, registered pharmacist, registered radio logic technologist, registered nuclear technologist, registered ultrasound technologist, or Associate Health Professional, may accept telephone orders from the Member respective only to his or her specialty. Telephone orders must be received directly from Members and must be countersigned by the responsible Member or a member of his or her established coverage group as soon as possible but no more than thirty (30) days after discharge (i.e., during the medical record completion process). However, any telephone orders for parenteral cancer chemotherapy must be countersigned by the ordering physician within twenty-four (24) hours. The accuracy and clarity of telephone orders, and any other verbal orders, shall be the responsibility of the Member who dictated the orders. All telephone orders must comply with these requirements.

7. The responsible Member or the ordering individual is responsible for discontinuing orders.

8. The policies and procedures referring to all drugs and medications administered to patients are completely outlined in the specific Formulary Policy at the Medical Center.

9. All requests for studies from ancillary areas such as Radiology, EKG, EEG, EMG, and Pathology, must be signed by the ordering physician or Member and will include pertinent history and physical examination findings as well as
pertinent laboratory studies justifying the need or reason for the examination.

10. All orders for controlled substances and I.V. piggybacks will automatically discontinued after seven (7) days unless the order indicates an exact number of doses to be administered or an exact time period for the medication is specified, or the responsible physician or Member re-orders the medication. The sentence “continue all orders” may not be used and renewal of medications must be specific for each item.

11. Orders for antibiotics must be recorded on the Antibiotic Order Sheet or its PCIS equivalent and will be automatically discontinued in accordance with the Antibiotic Order Policy unless the order denotes an exact number of doses to be administered, an exact time period for the medication, or the responsible physician or Member re-orders the medication.

12. All other medication orders (e.g., other than for controlled substances and I.V. piggybacks or antibiotics) will be automatically discontinued after ninety (90) days unless the attending physician re-orders the medication.

13. All Total Parenteral Nutrition (TPN) orders must be renewed every twenty-four (24) hours. TPN orders must be written by 12:00 Noon each day.

14. Respiratory Therapy Orders must be reviewed every twenty-four (24) hours for surgical patients and forty-eight (48) hours for medicine patients.

15. Laboratory Orders for ongoing or daily tests shall require renewal by written order after a three (3) day period.

16. Renewal Orders must be specific for each item. “Continue all orders” may not be used.

17. Pre-operative Orders: All pre-existing physicians’ or Members’ orders will be suspended when a patient undergoes surgery. Existing orders will be reactivated or new orders written by the surgeon following surgery. Exception is made for patients undergoing the following procedures: insertion of venous access devices, pacemakers, gastrostomy or jejunostomy tube placement, fistulas, tracheostomies, post-partum tubal ligations, or evaluation of fetal well being in the C-Section operating room suite.

18. Transfer in or out of any Critical Care Unit requires that all previous physicians’ or Members’ orders be re-written for the new nursing unit.

19. Orders for surgical specimen review must be supplemented by a requisition with the patient’s identification, the source of the specimen, the reason for the
examination and the pertinent clinical information including pre-operative and post-operative diagnoses.

20. Rehabilitation orders must include patient name, diagnosis, precautions, and the treatment or service to be provided. All orders for patients in the Medical Center for more than thirty (30) days must be renewed in writing every thirty (30) days.

21. If no dietary order has been written one half hour before meal service, a registered nurse may order one meal for a newly admitted patient who is in his or her estimation stable and has no contraindication to oral feeding.

22. DNR (Do Not Resuscitate) - See specific Medical Center policies regarding this procedure.

N. Discharge Summary

1. A discharge summary should concisely recapitulate the patient’s hospitalization, and shall include:

   a) Patient Identification;
   b) Chief Complaint: the reason for the hospitalization and pertinent past medical history;
   c) Hospital Course: a concise description of hospitalization, significant findings, procedures performed and treatment rendered including patient’s response, complications, consultations, etc.;
   d) Condition of patient on discharge;
   e) Final Diagnoses: using acceptable terminology, in full, without the use of symbols or abbreviations;
   f) Operations and Procedures: non-operative procedures such as endoscopy, lumbar puncture, and angiogram must be included; and
   g) Instructions for continuing care: including physical activity, diet, medications by name and dosage, and any referrals and appointments. (When pre-printed instructions are given to the patient, the record must so indicate).

2. A discharge summary must be written or dictated on all hospitalized patients except DayStay patients, normal newborns and uncomplicated obstetrical deliveries, and patients with problems of a minor nature who require less than a 48 hour hospitalization. Records for such excepted patients require a final progress note which must include outcome of hospitalization, disposition of the case, procedures performed, any instructions given to the patient, and final diagnoses.

   A discharge summary is required for all patients being transferred to acute rehabs,
nursing homes and rest homes regardless of length of stay.

3. In the event of death, a summation statement indicating the reason for the admission, the findings and course in the Medical Center, and the events leading to death is required regardless of the duration of the patient’s hospitalization.

O. Medical Record Completion

1. A medical record will be considered complete when the contents, including but not limited to the discharge summary, have been assembled and signed. When possible and practicable, all portions of the medical record of a Medical Center patient should be completed at the time of discharge.

2. The medical record, including the discharge summary, is considered delinquent when it remains incomplete thirty (30) days after discharge.

3. If resident staff is involved, they are required to complete their medical record responsibilities fourteen (14) days after patient’s discharge. Failure to do so will result in administrative action.

4. The Medical Records Department will notify Members in writing of the status of their incomplete records. Members will be advised of the impending deadline, and advised that the sanctions provided in the Medical Staff Bylaws will be automatically imposed if the record is not completed within the required time frame. A copy of any notice will be sent to the Medical Staff President and the Chair of the Department in which the Member has his or her principal affiliation. Failure to complete the record, which includes signature, no later than thirty (30) days after discharge, will result in automatic suspension of Medical Center privileges. Medical Center privileges shall include admitting privileges, operating room privileges, consultation privileges with respect to new patients, voting rights, and office holding prerogatives, as applicable. This suspension will not apply to patients already under the care of the suspended Member. The Member’s Medical Center privileges will remain suspended until all delinquent medical records have been completed or until such later time as may be applicable under Section 5 below.

5. On the fourth and with each subsequent automatic suspension within any twelve (12) month period for failure to complete records, the Member is completely suspended from Medical Staff membership and from the exercise of any clinical privileges for an additional seven (7) days beyond the date all records are completed. Additionally, said Member’s membership status may be reviewed by the Department, Credentials Committee, Medical Staff Executive Committee and/or the Board for possible further corrective action. If a Member has one or more records incomplete for four (4) or more weeks past the date of suspension,
and after special notice from the Medical Staff Executive Committee, the Member has failed to show good cause for such failure in the determination of the Medical Staff Executive Committee, the Member’s membership and clinical privileges shall be automatically terminated.

6. Should a patient be admitted to the Medical Center and expire or otherwise leave before the patient’s physician is able to see the patient, e.g., an admission through the Emergency Department, the patient’s physician is responsible for the completion of the Medical Center record even though the physician may not have seen the patient. If a patient is admitted through the Emergency Service to the service of his or her private physician, it is the responsibility of the Emergency Department physician to notify the private attending of any such admission.

7. A medical record will not be filed permanently until it is completed by the responsible Member or is ordered filed by the appropriate designated Medical Center or Medical Staff personnel. No Member is permitted to complete a medical record on a patient unfamiliar to him or her in order to retire a record that was the responsibility of another Member who is unavailable.

P. Medical Record Access

1. All medical records are the property of the Medical Center and shall not be removed from the Medical Center’s jurisdiction and safekeeping except as may be required by a court order or upon the express authorization of the Medical Center Chief Executive Officer or his or her designee. In case of readmission of a patient, all previous records shall be available for use by the responsible Member. This shall apply whether the patient be attended by the same Member or by another. Unauthorized removal of medical records from the Medical Center may be grounds for corrective action.

2. Members shall have access to patient medical records for bona fide study and research consistent with preserving the confidentiality of individually identifiable health information and otherwise consistent with Medical Center policy and relevant law. Subject to the discretion of the Medical Center Chief Executive Officer and consistent with Medical Center policy and relevant law, former Members of the Medical Staff may be permitted access to information from the medical records of their patients covering periods during which they attended such patients in the Medical Center.

3. Consistent with Medical Center policy and relevant law, an authorization signed by the patient is required for release of a copy of the medical record to persons not otherwise authorized to receive it.
III. **EMERGENCY ROOM CALL-WAIVER OPTION**

When a Member of the Medical Center Medical Staff has reached the age of sixty (60) or has twenty-five (25) years of service to the Medical Center and after having given twelve (12) months prior notice of his or her intent to his or her Department Chair, such Member shall have the option of discontinuing his or her Emergency Department call obligations.

IV. **INFORMING PATIENTS ABOUT THE OUTCOMES OF CARE**

A member of the Medical Staff in good standing, or his or her designee, shall clearly explain to the patient and, when appropriate, the family, the outcomes of treatments and procedures, including those outcomes that differ significantly from the anticipated outcomes. In keeping with these Rules and Regulations, Section II, Subsection H., the attending physician will also document in the medical record anticipated and unanticipated results of tests and treatment.

V. **PARTICIPANTS IN PROFESSIONAL GRADUATE EDUCATION PROGRAMS**

Consistent with and in addition to the requirements set forth in these BMC Medical Staff Rules and Regulations with respect to the clinical activities, supervision, and communication concerning residents and other participants in professional graduate education programs at BMC, Medical Staff Members shall comply with all BMC policies governing residents and other participants in professional graduate education programs at BMC, including those maintained by the BMC Office of Academic Affairs. Such BMC policies govern, among other things: (a) the process for supervision of such participants in carrying out their patient care responsibilities, (b) the identification of which participants may write patient care orders, and under what circumstances, and what entries, if any, must be countersigned by a supervising licensed independent practitioner, and (c) the mechanism for effective communication between the individuals and committees responsible for professional graduate education and the BMC Medical Staff and the BMC Board of Directors.

Amended effective June 10, 2003

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